Department of Health
Child and Adolescent Mental Health Division

Performance Report

Performance Period July 2006-September 2006

Introduction

This report presents data about the performance of the Child and Adolescent Mental Health Division (CAMHD) during the first quarter of fiscal year 2007 (July 2006-September 2006). Information is based on the most current data available, and where possible are aggregated at both statewide and district or complex levels. It is a basic accounting of the results of the CAMHD program in providing services for youth in the State of Hawaii with the most intensive mental health needs. The information is provided to share up to date data with CAMHD stakeholders regarding how well care is delivered and how well child outcomes are achieved. It is also used to guide decisions by management about adjustments needed in the CAMHD program.

Data in this report are presented for four major areas:

- Population: Population information describes the demographic characteristics of the children and youth served by CAMHD.
- Service: Service information is compiled regarding the type and amount of direct care services provided.
- Cost: Cost information is gathered about the financial aspects of services.
- Performance Measures: Performance Measures, including outcome data, are used to understand and track the quality of services over time and the performance of operations of the statewide infrastructure designed to provide needed supports for children, youth, and families. Outcomes are further examined to determine the extent to which services that are provided lead to improvements in the functioning and satisfaction of children, youth and families.

How Measures Are Selected and Used

CAMHD uses performance measures to track the quality and performance of its program. Performance is measured to determine how well services are provided, and how well the service delivery infrastructure is maintained. Performance measures are used throughout the system to align organizational goals with achieving results. They coordinate the work of the organization in order to achieve timely, cost-effective services that are designed to improve the lives of children, youth and families served.

The CAMHD Performance Management system allows CAMHD at all levels to use data to make decisions about any needed adjustments to its program. Performance data in CAMHD are tracked systematically across all aspects of service delivery and care including service utilization, program performance, consumer satisfaction, examination of practice, and quality of services. This information helps determine how well the system is doing for youth, and how well youth are progressing. It is sensitive enough to ascertain if the system is performing better or worse for certain populations, and

comprehensive enough to detect what aspects of care, and in what settings, problems may be occurring.

Further studies and special reports on the CAMHD population and services, including past editions of this report can be accessed at the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/resources/index.html.

Quality Improvement Highlights during the Reporting Quarter

Highlights of key activities conducted during the quarter include:

⇨ Public hearings to gather comments on the proposed CAMHD Strategic Plan covering the next four years (2007-2010) were conducted statewide. During the quarter, broad-based writing teams used input gathered from stakeholders to formulate work plans for achieving outcomes in the six priority areas of the proposed Strategic Plan. After the plans are adjusted based on feedback from the public hearing process, the Strategic Plan will be presented to the Legislature. The priority areas are:

- Decrease Stigma and Increase Access to Care
- Implement and Monitor Effectiveness of Comprehensive Resource Management Program
- Implement a Publicly Accountable Performance Management Program
- Implement and Monitor a Workforce Practice Development Program
- Implement and Monitor a Strategic Personnel Management Program
- Implement and Monitor a Strategic Financial Plan
- Implement and Monitor Strategic Information Technology Program

⇨ Services began pursuant to the FY 2007 CAMHD Request for Proposals (RFP) for Home and Community-Based Services. A number of residential service providers reported being impacted by fewer referrals. Omitted sentence .A new RFP has yet to be issued for several specific services and services in particular communities that were not awarded due to non-response to the RFP awarded in July.

Several services are pending implementation of a signed Memorandum of Agreement between CAMHD and the Med-WQUEST Division. As well, a number of awarded services are awaiting startup until a new Medicaid State Plan Amendment is submitted to the federal government that will add services to the existing State Plan. CAMHD provision of Acute Psychiatric Hospital services for Medicaid-eligible CAMHD youth has been postponed until April 2007 due to a delay in awards of the medical RFP by the Med-QUEST Division of the Department of Human Services. Until April, Acute Psychiatric services will continue to be provided through the QUEST Health Plans.

⇨ The Governor recently announced that Hawaii was awarded a Mental Health Transformation grant by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) Hawaii. Hawaii is one of eight states to receive the coveted five-year grant that will allow Hawaii to develop policy initiatives across state departments and the community to transform the mental health services delivery system. First year products will be a needs assessment, a resource inventory, and development of a Comprehensive State Mental Health Plan. Although Hawaii has made great strides over the last decade, much work remains to

assure that every individual with mental health issues can have a productive life in the community.

Among the commitments Hawaii described in its Mental Health Transformation grant application are:

- Campaign to reduce stigma
- Reduce disparities including those that are due to lack of cohesive mental health policies
- Build infrastructure for continuing education for providers
- Empowerment of consumers and families statewide
- Individualized plans of care for each person receiving mental health services
- Efficient use of federal funding and mandates
- Assure early screening, assessment and treatment-build more capacity in primary care settings
- Build data-driven performance management systems
- Promote research and workforce development
- Advance telemedicine and electronic medical records.

⇨ During the first quarter of the fiscal year, CAMHD's Practice Development Team implemented a number of Cross-System Training Initiatives, working closely with other state agencies to provide training on topics that are of common concern. These cross-system training initiatives included:

- Statewide training for DHS staff on referring youth for CAMHD services through the SEBD program and on the array of mental health treatment services available to youth in the SEBD program in the new Interagency Performance Standards & Practice Guidelines (a total of 8 sessions offered during the first quarter).
- Statewide training for DHS staff conjointly with CAMHD staff on Evidence-Based approaches to treating youth with attachment problems.
- Training for Oahu Family Court staff, primarily probation officers on working with youth who exhibit suicidal or parasuicidal behavior.

⇨ The Practice Development Team continued to work on disseminating Evidence Based Practices to contracted providers, including the introduction of a strong new evidence-based treatment package – Multidimensional Treatment Foster Care (MTFC) – to the Hawaii service array. During the first quarter, the developers of the MTFC approach came to Hawaii from Oregon, and provided eight full days of training on the model. Attendees included CAMHD staff, providers from the two agencies who are piloting the approach, and foster parents who will be working in the two pilot sites.

Evidence-based training efforts also included several daylong workshops for CAMHD system therapists on the use of Dialectical Behavior Therapy (DBT) with Adolescents. DBT is a form of cognitive behavioral therapy used with youth who have severe difficulties in the area of emotional dysregulation.

CAMHD has been promoting a free web-based training opportunity in the area of Trauma Focused Cognitive Behavior Therapy. Twice-monthly phone conference sessions are offered for those taking the on-line course as a way to support completion of the online modules.

Training efforts also were focused on maintaining fidelity in existing Evidence-Based treatment offerings. Quarterly Booster training in Multisystemic Therapy (MST) was held for MST teams statewide, and informational sessions about MST were provided to staff at two Family Guidance Centers.

- CAMHD convened a cross-system discussion about the issues surrounding access to services for youth that involved with multiple agencies. The meeting was very well attended, and included a Family Court Judge, probation officers, family members and representatives from provider agencies, Child welfare, Department of Education, and the Office of Youth Services. The goal was to allow those involved to become more familiar with the various contracts held by different state agencies, and to begin planning ways to streamline referrals to agencies through collaboration. Since then CAMHD, Child Welfare, the Judiciary and the Office of Youth Services have drafted a tracking system that will allow users to share information about the various contracts, as well as current availability of out-of-home services. A follow-up meeting is scheduled for the first week of December.

Overall Findings for Quarter One, Fiscal Year 2007

- The overall results for the reporting quarter, based on analysis of performance presented in this report suggest that CAMHD's functioning continues to be comparable to that of previous quarters in a number of indicators. However, due to the continued and growing problem of vacancies experienced across the Division, there was a marked decline in a number of critical areas including: ability to fill positions in a timely way, caseloads, timely access to services, and quality committee performance. Human resources, particularly the hiring and retaining qualified mental health care coordinators and central office administrative staff continue to challenge CAMHD's ability to maintain a stable service delivery infrastructure.

- Nearly half (45%) of CAMHD's measures were not met in the quarter, which is the same result as last quarter's performance (January through March 2006). This is 12% decrease over the same period as last year (July-September 2005) when 33% of measures were not met.

- The total number of youth served declined over the previous quarter by 1%, and CAMHD reversed its year-to-year trend of increasing its population. Decreases in the registered population were experienced in more than half of the Family Guidance Centers.

- Service utilization trends for Hospital-based Residential Services increased, as did the use of Community-based Residential services. The percentage of families in the CAMHD population receiving intensive in-home services decreased, although a subset of those services (Multi-Systemic Therapy) increased. Utilization of Therapeutic Foster Homes increased over the previous quarter, and also increased over the same period last year.

Overall, core infrastructure measures, primarily in the area of sufficient staffing, are showing a number of signs of a weakened ability to provide comprehensive services to the intended population. As suggested in previous reports, these trends and the reasons for current performance suggest that policy-level interventions are needed to ensure that

the gains that have been made previously are sustained. The two core issues that State leadership must grapple with is how to increase timely access to services for youth who are experiencing serious mental health issues, and how to assure timely hiring of qualified care coordinators and other critical personnel.

Data Sources

Data regarding the population served, access and use of services, cost, treatment processes and outcomes is generated at the Family Guidance Centers or through billing information, and collected through the Child and Adolescent Mental Health Management Information System (CAMHMIS). CAMHMIS produces data reports that are used by staff and management for tracking, decision-making, supervision and evaluation. CAMHMIS' multiple features include the ability to generate "live" client data, FGC-specific reports and other special reports that aid in performance analysis and decision-making. Additional data elements used to track Performance Measures are produced by various databases maintained at the State Level.

Population Characteristics

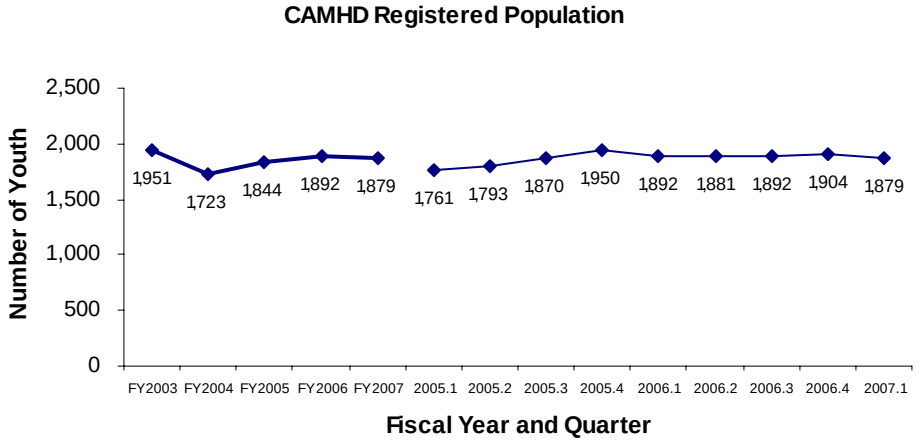
Population data presented here are for youth registered at the CAMHD Family Guidance Centers during the first quarter of fiscal year 2007 (July 2006-September 2006). In the quarter, CAMHD Family Guidance Centers provided care coordination for 1,879 youth across the State, a decrease of 25 from the previous reporting quarter (April 2006-June 2006 based on data as of June 30, 2006), or a 1% decrease in the total population over last quarter. Decreases in the registered population were experienced in more than half of the Family Guidance Centers.

The trend of overall year-to-year growth reversed this quarter. In comparison to the same period of last year (July 2005-September 2005), CAMHD experienced a 1% overall decrease in its registered population. CAMHD continues to serve far fewer youth statewide than expected based on estimates of the prevalence of severe emotional and behavioral problems in the general population.

Nationally, it is projected that 5-9% of all youth ages 9-18 have a serious emotional disorder at some point during their childhood. CAMHD served less than 1% of the State's population during the quarter. While it would not be expected the CAMHD would serve all of the youth needing services as youth are also served by schools and in primary care settings. 120
Given the presence of School Based Behavioral Health, a fair projection would be that CAMHD would serve at least 3% of the population needing services.

Access to CAMHD mental health services for the target population remains a critical issue facing the system of care. Despite many discussions on the penetration rate taking place in CAMHD and among stakeholders, very little impact has been observed in increasing access to intensive mental health services.

The chart below reflects changes in the CAMHD population over time.



The numbers of youth registered during the first quarter at each of the Family Guidance Centers are displayed in Table 1 below.

Table 1. Population of Youth Registered by Family Guidance Center

	COFGC	LOFGC	MFGC	WFGC	HOFGC	HFGC	KFGC	FCLB
First Quarter FY 2007	130	263	139	150	162	470	512	50
Fourth Quarter FY 2006	146	252	158	148	164	460	522	51
First Quarter FY 2006	168	255	155	149	180	431	514	40

Please note that the numbers for Kauai (KFGC) are for the Mokihana Project in total, which serves youth with both those with less serious emotional challenges as well as those youth with the more serious and prolonged needs. Of the 512 youth registered in Kauai, 93 or 4.9% are receiving intensive mental health services. Also displayed for each Family Guidance Center are the numbers for the preceding quarter (Quarter 4, FY 2006), and the numbers for the same period one-year ago (Quarter 1, FY 2006). The data show considerable declines in population in the Central, Maui and Honolulu districts, and a stable population for the Windward and Kauai districts. Leeward Oahu has experienced a moderate increase, and the Big Island has had the most significant increase in population.

In the current quarter (Quarter 1, FY 2007), the largest population, consistent with historical data, continued to be served on the Big Island through the Hawaii Family Guidance Center (HFGC). HFGC served 25.0% of the total CAMHD population during the quarter. The Leeward Family Guidance Center (LFGC) served the largest population on Oahu, which is 14.0% of the CAMHD registered youth. The Family Court Liaison Branch (FCLB), which provides services primarily for incarcerated and detained youth, continued to serve the smallest registered population (2.7%).

The total number of registered youth are described by four subgroups: (*i*) youth who received both intensive case management services and direct services authorized through the CAMHD provider network, (*ii*) youth who were in the process of having services arranged (new admissions), (*iii*) youth who received less intensive services through Mokihana on Kauai, and (*iv*) youth who were discharged at some time during the quarter. There is also a percentage of youth who receive intensive case management services only. Of the total number of registered youth, 951 had services that were authorized within the quarter.

Of the total registered population statewide (1,879), 151 youth (8.0%) were newly registered (had not previously received services) in the first quarter of fiscal year 2007. This is consistent with the number of new admissions (151) from the previous quarter (April 2006-June 2006). Ninety-one (91) youth (4.8%) who had previously received services from CAMHD were reregistered, a decrease from last quarter's readmissions of 109 youth. CAMHD discharged a total of 191 youth during the quarter, or 10.2% of the registered population. This is a decrease of 57 youth from last quarter's discharge of 248 youth, which was 13.0% of the registered population. Because youth may receive multiple admissions or discharges during the quarter for administrative reasons, these numbers estimate, but do not exactly reflect changes in the overall registered population size. Youth are generally discharged for several reasons, which can include attaining

desirable treatment outcomes, graduation from school or "aging-out" of services, treatment refusal or program elopement, or moving out of state.

This pattern of admissions and discharges suggests that the reduction in the total registered population is resulting from a decrease in the number of new admissions, not an increase in the number of discharges. In other words, the services for youth registered with the system apparently proceeded as is typical, but "pathways" into the system provided fewer youth. Fewer admissions into CAMHD is fairly typical during the summer months due to fewer referrals from DOE and is consistent with the year-to-year pattern.

The average age and age range of youth remained stable. The average age of registered youth in the reporting quarter was 14.3 years with a range from 3 to 21 years. Approximately two-thirds (67%) of youth served during the first quarter were male (see Table 2).

Table 2. Gender of CAMHD Youth

Gender	N	% of Available
Females	629	33%
Males	1,250	67%

The national origin of youth is displayed in Table 3. The races of youth registered in the reporting quarter are displayed in Table 4. The valid completion rates for the new procedures continued to be low with 61.8% of youth missing national origin information and 43.4% of youth missing race information, which continues to limit the generality of the available data. Race data were even less available this quarter than last quarter when 48.6% did not have race data recorded. A recommendation regarding improving data completion will be made to CAMHD's Performance Improvement Steering Committee. However, the observed results for both data sets continued to be relatively consistent with prior quarters.

In the quarter, multiracial youth represented the largest racial group (62.1%), followed by White youth (16.1%), and then Native Hawaiian or Pacific Islanders (10.4%).

Table 3. National Origin of Youth (Unduplicated)

National Origin	N	% of Available
Not Hispanic	488	68.0%
Hispanic or Latino/a	230	32.0%
Not Available (% Total)	1,161	61.8%

Table 4. Race of Youth (Unduplicated)

Race	N	% of Available
American Indian or Alaska Native	3	0.3%
Asian	92	8.6%
Black or African-American	16	1.5%
Native Hawaiian or Pacific Islander	111	10.4%
White	171	16.1%
Other Race	10	0.9%
Multiracial	661	62.1%
Based on Observation	123	11.6%
Not Available (% Total)	815	43.4%

Subpopulations of youth who receive services through CAMHD are also involved with other public child-serving agencies. These agencies include the Department of Human Services (DHS), Family Court, Hawaii Youth Correctional Facility (HYCF) or Detention Home, and the Med-QUEST Division of DHS (see Table 5). In the quarter, 9.5% were involved with DHS, which is the same as the same period of FY 2006. At some point during the quarter, 21.7% had a Family Court hearing, and 4.8% were incarcerated at HYCF or detained at the Detention Home. The proportion of youth who had a Family Court hearing decreased slightly from the previous quarter (22.1%), although the proportion of youth who were incarcerated or detained remained unchanged (4.8%). Both proportions remained below the same period as last year (25.2% and 6.8%, respectively).

Table 5. Agency Involvement

Agency Involvement	N	%
DHS	178	9.5%
Court	408	21.7%
Incarcerated/Detained	90	4.8%
SEBD	831	44.2%
Quest	738	39.3%

Services to youth who are QUEST-eligible and have a Serious Emotional and Behavioral Disturbance (SEBD) occur by virtue of a Memorandum of Agreement (MOA) with the Med-QUEST Division. Youth who were eligible for services through the SEBD process numbered 831 and were 44.2% of the registered population. This was an increase of 32 youth, or a 4% increase in the SEBD category over the previous quarter (April 2006-June 2006).

QUEST-eligible youth who received services in the quarter were 39.3% of the population. This proportion of QUEST enrolled youth increased from the previous quarter's slightly lower proportion (38.0%), as well as number (723), of youth. The data showed an increase in proportion of the population in the reporting quarter, which continues the pattern of expanding services to QUEST youth. QUEST-eligible youth may also be eligible for services through CAMHD because of their educational or juvenile justice status.

Table 6. Diagnostic Distribution of Registered Youth

Any Diagnosis of	N	%
Disruptive Behavior	835	50.3%
Attentional	671	40.4%
Mood	545	32.8%
Miscellaneous	431	25.9%
Anxiety	327	19.7%
Substance-Related	278	16.7%
Adjustment	163	9.8%
Mental Retardation	34	2.0%
Pervasive Developmental	41	2.5%
Multiple Diagnoses	1,183	71.2%
Ave. Number of Diagnoses	1.9	

Note: Percentages may sum to more than 100% because youth may receive diagnoses in multiple categories.

Youth registered with CAMHD receive annual diagnostic evaluations using the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; American Psychiatric Association, 1994). Children and youth may receive multiple diagnoses on the first two axes of the DSM system. To summarize this information, diagnoses are classified into primary categories and the number of youth receiving any diagnosis in each category is reported (see Table 6). The reported percentages may exceed 100% because youth may receive diagnoses in multiple categories.

The top three diagnoses of youth with registered services in the quarter were Disruptive Behavior disorders (50.3%), Attentional disorders (40.4%), and Mood disorders (32.8%), a pattern consistent with the last several quarters. This quarter saw a slight increase in the number of youth with Attentional disorders, although there continues to be more youth with Disruptive disorders. Miscellaneous diagnoses

accounted for 25.9% of youth in the CAMHD population. This category includes individual diagnoses that occur less frequently in the population including cognitive, psychotic, somatic, dissociative, personality, sexual, tic, impulse control, learning and eating disorders.

The majority of youth in the CAMHD registered population have co-occurring, or more than one diagnosis. In the reporting quarter, 71.2% of registered youth had more than one diagnosis, with an average of 1.9 diagnoses per youth. This is a slight decrease from the previous quarter (April 2006-June 2006) when 71.5% had co-occurring disorders. For those with services authorized, the percentage of youth with multiple diagnoses was even higher (78.8%) with an average of 2.2 diagnoses per youth, which means that over three quarters of youth that received services within the CAMHD array in the quarter had co-occurring diagnoses. This continues a long-term pattern of increasing diagnostic comorbidity among youth receiving CAMHD services. The co-occurring diagnoses category includes any DSM-identified disorder whether behavioral, developmental, emotional or substance-related.

In the quarter, youth with substance-related diagnoses represented 16.7% of the registered population, an increase of .7% from the previous quarter. This statistic may not represent all youth with a substance-related impairment, or the number of youth with substance use identified as a target of intervention. Because diagnostic criteria for substance-related disorders require youth to exhibit a variety of symptoms and impairment, not all youth who use substances or who might benefit from interventions targeting substance use would be diagnosed with a substance-related disorder. Therefore, this statistic, which is drawn from the diagnostic category, is expected to underestimate the total number of youth experiencing a substance-related impairment.

Services

Service utilization information is used throughout CAMHD to assure efficient use and timely access to services. At the case level, service data are constantly reviewed to provide services based on child and family needs, and provision within the least restrictive environment. Tracking of utilization of the services at the aggregate level allows for accurate accounting, and data-driven planning and decision-making.

The utilization of services data (based on authorized services) for Quarter One, Fiscal Year 2007 (July 1, 2006 – September 30 2006) are displayed below in Table 7.

Table 7. Service Authorization Summary (July 1, 2006-September 30, 2006).

Any Authorization of Services	Monthly Average	Total N	% of Registered	% of Served
Out-of-Home	**308**	**380**	**20.2%**	**40.0%**
Out-of-State	7	7	0.4%	0.7%
Acute Hospitalization or Detoxification	0	0	0.0%	0.0%
Hospital Residential	24	36	1.9%	3.8%
Community High Risk	12	13	0.7%	1.4%
Community Residential	89	128	6.8%	13.5%
Therapeutic Group Home	55	72	3.8%	7.6%
Therapeutic Group Home	*50*	*65*	*3.5%*	*6.8%*
Community Mental Health Shelter	*5*	*10*	*0.5%*	*1.1%*
Therapeutic Foster Home	135	172	9.2%	18.1%
Multidimensional Treatment Foster Care	*1*	*3*	*0.2%*	*0.3%*
Therapeutic Foster Home	*134*	*169*	*9.0%*	*17.8%*
Intensive Home and Community	**483**	**584**	**31.1%**	**61.4%**
Partial Hospitalization	0	1	0.1%	0.1%
Multisystemic Therapy	105	140	7.5%	14.7%
Intensive In-Home	379	454	24.2%	47.7%
Intensive Outpatient	1	2	0.1%	0.2%
Outpatient	**70**	**167**	**8.9%**	**17.6%**
Treatment	3	5	0.3%	0.5%
Medication Management	*1*	*3*	*0.2%*	*0.3%*
Functional Family Therapy	*0*	*0*	*0.0%*	*0.0%*
Outpatient Therapy	*2*	*2*	*0.1%*	*0.2%*
Parent Skills Training	*0*	*0*	*0.0%*	*0.0%*
Consultation	56	132	7.0%	13.9%
Assessment	12	34	1.8%	3.6%
Supportive Services	**118**	**178**	**9.5%**	**18.7%**
Respite Home	0	0	0.0%	0.0%
Respite Support	33	36	1.9%	3.8%
Peer Support	0	0	0.0%	0.0%
Ancillary Service (Flex-Funded)	87	145	7.7%	15.2%
Crisis Stabilization	**0**	**1**	**0.1%**	**0.1%**

Note: Acute Hospitalization or Detoxification, Respite Home, and Peer Support services were not included in the standard service array during the current reporting period. Youth may receive more than one service per month and not all youth will have a service procured each month, so the percentages may add to more or less than 100%. The monthly average to total census ratio is an indication of youth turnover with a high percentage indicating high stability.

AMHD tracks the utilization of services through CAMHMIS for services that are electronically procured. For services that are not electronically procured, information from the Clinical Services database is used to augment the CAMHMIS database to yield the final numbers reported here. CAMHD produces a separate detailed quarterly service utilization report with information regarding statewide utilization of services for all levels of care. As discussed previously, because utilization data are dependent on an accounting of claims adjudicated, it is not possible to present actual utilization for the current reporting quarter (July 2006-September 2006). Therefore, service authorization data are presented here, which closely approximates the actual utilization for the quarter for most levels of care.

Services represent many of the additional levels of care that were implemented beginning this fiscal year subsequent to the awards of new contracts for an expanded service array. There was no service utilization for Acute Hospitalization due to delays in the Med-QUEST RFP process. Substance-Abuse Detoxification, Parent Skill Training, and Peer Support services for Medicaid eligible youth have not yet been initiated, as they are not yet part of the Medicaid State Plan. There was no utilization for Functional Family Therapy, and Intensive Outpatient Services as these services have not yet been brought up by awarded provider agencies.

Services provided in homes and in the community continued to account for the majority of services provided to youth. Specifically, 47.7% of youth with services authorized received Intensive In-Home (IIH) services and 14.7% received Multisystemic Therapy (MST). Compared to the previous quarter, the percentage of youth (51.5%) receiving Intensive In-Home services showed a decrease, whereas the percentage of youth (13.9%) receiving Multisystemic Therapy services showed a slight increase.

The largest group of youth in an out-of-home setting received services in a Community-Based Residential program (13.5%). The percentage of youth receiving these services increased slightly from the previous quarter (13.0%), however the proportion of youth receiving these services decreased considerably from the same period of last year (15.4%). The trend toward decreasing utilization of Hospital-Based Residential (HBR) in recent quarters was reversed in the first quarter. The use of HBR services (3.8% during period) increased noticeably from the previous quarter (2.7%), and increased from the same period last year (3.2%).

The utilization of Therapeutic Foster Homes (17.8%) increased this quarter over the previous quarter (15.2%) and increased over the same period of last year (15.9%). Multi-Dimensional Treatment Foster Care (MTFC), a brand new evidence-based service saw the first few youth to receive this service during the quarter. Utilization of Therapeutic Group Homes decreased significantly this quarter (6.8% as compared to 9.4% last quarter) and was also below utilization of the same period as last year (9.6%).

Reporting starting this fiscal year will display utilization for the group of services characterized as Supportive Services. Supportive Services are designed to maintain youth in their homes (prevent out-of-home placements) through supports that are not found in the regular array of services, or to pay for specialized services. They include Respite Homes, Respite Supports, Peer Support, and Ancillary Services funded through Flexible Funding. As discussed above, Peer Supports are not yet part of the Medicaid State Plan and without this, CAMHD does not have a funding source for this service. Peer Supports are seen as a low-cost supportive service that is a part of the service array in many other states.

Ancillary Services were provided for 15.2% of registered youth, which was a decrease from last quarter's utilization of these services for 15.8% of the registered population. The largest use of Ancillary Service funding was to pay for travel cost for youth in out of home settings.

Respite Homes are designed to support caregivers' capacities and prevent potential out-of-home placements. In the reporting period, there was no use of Respite Homes. In CAMHD's new RFP, payment for Respite Homes was restructured to remove any access obstacles. The last time the services were utilized was during the first quarter of fiscal year 2006, when it was accessed by 0.6% of youth. Tracking of the utilization of Respite Homes will be important once the service is brought up to see if the new payment structure has addressed access issues.

Intensive Day Stabilization was replaced with Partial Hospitalization in the new RFP. In the reporting quarter, 0.1% of youth utilized this service. No youth accessed the service in the previous quarter.

Respite Support services are a different level of care than Respite Homes in that they do not need to be provided by a Therapeutic Foster Home provider and are more flexible in nature. Utilization of Respite Support services increased with 3.8% of youth accessing these services in the quarter as opposed to 2.8% last quarter.

Cost

CAMHD uses several sources of information about expenditures and the cost of services to understand cost across all services delivered. Services billed electronically and purchased through the provider network are recorded directly by CAMHMIS when the records are approved for payment (a.k.a. accepted records). Because cost data are available the quarter following the adjudication of all claims, the cost data discussed below represents expenditures for services provided during the fourth quarter of fiscal year 2006 (April 2006-June 2006). Unit cost information may not be available in CAMHMIS for certain types of services or payment arrangements (e.g., cost reimbursement contracts, emergency services). For these services, wherever possible, service authorizations are used to allocate the cost of services (e.g., Flex, Mokihana, Multisystemic Therapy, Out-of-State, Respite) to specific youth and Family Guidance Centers.

Detailed allocation of cost information for the reporting quarter by each level of care is presented in Table 8. Beginning next quarter, service costs will be presented for the expanded array of services displayed in Table 7 of this report.

For the reporting quarter, Out-of-Home residential treatment services accounted for 80.6% of service expenditures, which is 0.4% above the previous quarter's percentage of cost. Youth in Out-of-State treatment settings accounted for 1.4% of total expenditures, which is 0.2% below the previous reporting quarter's (January 2006-March 2006) proportion of cost.

Table 8. Cost of Services (April 2006-June 2006)

Any Receipt of Services	Total Cost ($)	Cost per Youth ($)[a]	Cost per LOC ($)[b]	Cost per LOC per Youth ($)[b]	% of LOC Total ($)[b]
Out-of-State	162,658	23,237	135,470	19,353	1.4%
Hospital Residential	1,061,170	39,303	803,160	29,747	8.2%
Community High Risk	486,303	44,209	456,885	41,535	4.7%
Community Residential	3,545,019	27,914	3,016,484	23,752	30.8%
Therapeutic Group Home	1,993,230	22,396	1,646,566	18,501	16.8%
Therapeutic Family Home	2,472,493	16,266	1,964,118	12,922	20.1%
Respite Home	0	0	0	0	0.0%
Intensive Day Stabilization	0	0	0	0	0.0%
Partial Hospitalization	0	0	0	0	0.0%
Day Treatment	0	0	0	0	0.0%
Multisystemic Therapy	693,937	4,992	419,524	3,018	4.3%
Intensive In-Home	2,163,926	4,565	1,007,963	2,127	10.3%
Flex	3,546,216	22,303	215,533	1,356	2.2%
Respite	254,291	6,692	44,361	1,167	0.5%
Less Intensive	49,272	9,854	9,381	1,876	0.1%
Crisis Stabilization	205,177	12,824	67,208	4,200	0.7%

Note: a Cost per youth represents the total cost for all services during the period allocated to level of care based on duplicated youth counts. Thus, the average out-of-state cost per youth includes total expenditures for youth who received any out-of-state service. If youth received multiple services, the total expenditures for that youth are represented at multiple levels of care (duplicated US$). b Cost per LOC represents the unduplicated cost (US$) for services at the specified level of care.

The quarter experienced an increase in the average length of service in the Hospital setting, although the number of youth receiving Hospital-Based Residential services remained the same. Total cost of services for youth who received Hospital Residential services during the quarter decreased slightly from $1,066,813 to $1,061,170. The cost for Hospital-Based Residential services increased from $803,160 compared to $780,560 in the prior quarter. Conversely, the cost per youth decreased from $41,031 to $39,303 for total costs and from $30,022 to $29,747 for Hospital Residential costs only.

The cost of CBR services increased in the reporting quarter (i.e., fourth quarter of fiscal year 2006 compared to third quarter of fiscal year 2006) both in terms of total dollars and average cost per youth. Youth with high-risk sexualized behaviors who received treatment services in a Community High-Risk Program at some point during the quarter continued to have the highest total cost per youth ($44,209 per youth), but showed a decrease from the previous quarter. For other types of residential treatment, the lowest cost per youth was for those who received services in Therapeutic Foster Homes ($12,922 per youth), which has been consistent over time, and stands out as the most cost-effective residential service in addition to being the least restrictive.

In-Home (Intensive In-Home and MST) and Less Intensive services accounted for 14.7% of the unduplicated cost of services. This is a slight increase from the last reporting quarter (April 2006-June 2006) percentage of total costs for those categories, and this has been a trend over the past seven quarters, corresponding to less utilization of residential services. Youth receiving Intensive In-Home services at some point during the quarter cost an average of $4,565 per youth ($2,127 of which was for Intensive In-Home service expenditures only), which continues to be significantly less than the cost per youth in any residential program.

For those youth who received Ancillary Services, average cost per youth was only $1,356 per month and the average cost for all services to those youth who received one or more Ancillary services was $22,303 per youth. The average cost per youth for a child receiving an ancillary service at some point during the quarter also includes their service costs in other levels of care, and may include residential services. The high average total cost per youth for these services suggest that youth in out-of home placements account for a high percentage of youth receiving a Flex-funded service. A high proportion of ancillary services are travel-related including family visits when placement is off-island. As previously reported, CAMHD is in the process of adding travel costs to the MOA with the Med-QUEST Division for QUEST-eligible youth, allowing the State to recoup federal funds for a portion of this cost. This agreement will apply retrospectively.

Comprehensive information on expenditures beyond the services tracked by CAMHMIS is obtained through the Department of Accounting and General Service's Financial Accounting Management Information System (FAMIS). For this report, FAMIS provided information regarding total general fund expenditures and encumbrances for the central and branch offices that are reported in the Performance Measures section. However, it is important to note that FAMIS tracks payments and encumbrances when they are processed at the Departmental level. Due to the time lag between service provision and payment, the CAMHMIS and FAMIS systems do not track the same dollars within any given period. Therefore, estimates provided here are used for general guidance, and detailed financial analysis is conducted by CAMHD Administrative Services.
Recent developments to the chart of accounts in the financial accounting system allows for more specific coding of purchases into specific service categories. Therefore, as the system continues to develop and new reporting functions are programmed,

comprehensive financial reports providing detailed service expenditures should be available from FAMIS. This should lead to reduced burden for manual reporting and increase the capacity of the fiscal section to perform timely and thorough financial analysis.

Services for Youth With Developmental Disabilities

CAMHD entered into a Memorandum of Agreement (MOA) with the Developmental Disabilities Division (DDD) of the Department of Health in July 2002 for the purposes of serving the needs of those youths with mental retardation and/or developmental disabilities and/or autism (target population) who had previously received respite and out-of-home services through CAMHD. The MOA transferred funding and personnel to DDD so that these children could receive appropriate individualized supports consistent with national best practices in developmental disabilities.

The table below summarizes the expenditure of dollars for respite services provided by DDD from July 1, 2002 through September 30, 2006:

Table 9. Expenditures to Date for Respite by Island

Island	# Youth Served	% of Total Youth	Total Cost Per Island	% of Total Dollars Expended	Average Cost Per Youth
Oahu	73	55%	$148,303.93	44%	$2,031.56
Hawaii	34	26%	$89,714.00	27%	$2,638.65
Kauai	11	8%	$61,644.50	18%	$5,604.05
Maui	14	11%	$37,358.00	11%	$2,668.43
Total Youth	132	Total Dollars Expended (July 2002 - September 30, 2006)			$337,020.43

Note: There are currently no reports of respite expenditures for the period July 2006 through September 2006.

Although the MOA ended on June 30, 2004, DDD continues to provide case management, individual support, respite, and out-of-home support services for the identified target population. DDD utilized the respite monies transferred from CAMHD as part of its state match for its HCBS-DD/MR Medicaid waiver program, thereby maximizing state funds and qualifying DDD services for federal reimbursement.

Respite Services

The target population received at least one support service from the DDD service system. For this current quarter, July 1, 2006 through September 30, 2006, the following table shows the utilization of various DDD funded services (short term) that families accessed to meet their needs:

Table 10. Other Service Options Utilized by Respite Recipients

DDD Funded Services	# of Users
Purchase of Services - Partnerships in Community Living	*Not available
DOH - DDD Respite	40
Family Support Services Program	9

Note: Partnerships in Community Living data to be reported in 2nd quarter report.

Since July 2002, DDD has admitted 65 of the target population into the Home and Community Based Services – DD/MR (HCBS-DD/MR) Medicaid waiver program. There were no discharges in the first quarter of FY '07.

Based on the latest expenditure information available for the period April 1, 2006 through June 30, 2006, the following table shows the number of clients in the target population and total dollars spent for two of the HCBS-DD/MR Medicaid waiver services, respite and personal assistance:

Table 11. Waiver Service Options Utilized by Respite Recipients

Waiver Services (April 1, 2006 – June 30, 2006)	# of Clients	Total $
Respite	4	$19,037.00
Personal Assistance	37	$436,282.00

Note: Amounts are rounded off to the nearest dollar.

Residential Services

The Individual Community Residential Support (ICRS) contract ended on June 30, 2006. As of July 1, 2006, Residential Habilitation Services Level 4 was added as a new service under the HCBS-DD/MR Medicaid waiver to continue the provision of out of home residential support services in a special treatment facility (STF) setting. Currently, residential habilitation services are provided in the STF for two youth.

The HCBS-DD/MR Medicaid Waiver has provided supports and services for all but one of the thirteen youth originally served. In addition, all youth that have aged-out of residential services and the DOE have continued services under the Waiver.

Performance Measures

CAMHD performance measures to demonstrate adequacy of services, results, infrastructure, and key practice initiatives are found in this section. If baseline performance falls below the established goals, CAMHD systematically examines the trends and any barriers, and develops strategies to achieve each goal. A stable pattern of results (i.e., a flat line) indicates that CAMHD is sustaining performance at baseline levels. A line that exceeds its benchmark indicates that CAMHD has surpassed its performance goals.

Performance measures linked to "measures of sustainability" are noted by an asterisk (*).

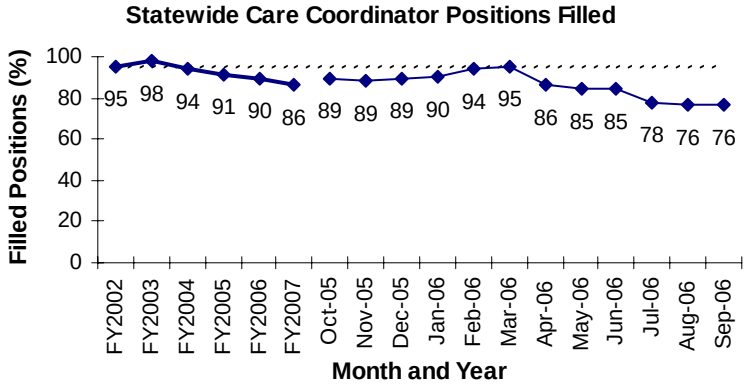
CAMHD will maintain sufficient personnel to serve the eligible population

Goal:

⇨ **95% of mental health care coordinator positions are filled.***

The data for this measure was adjusted beginning last quarter to reflect the actual number of filled care coordinator positions, and does not include positions filled by temporary employees (89-day hires). Filling positions with 89-day hires does not fully assure the provision of case management services by trained personnel.

Over the reporting period, CAMHD had an average of 77% of care coordinator positions statewide filled, which was 18% below the performance goal of 95% filled positions, and 8% below last quarter's performance. This quarter's result reflects the eleventh consecutive quarter the performance goal was not met, and the lowest percentage of filled care coordinator positions since reporting on this measure began in 2001.



The length of time it takes to fill care coordinator positions within the State personnel hiring process continues to be a significant factor in meeting this performance goal. Please see last quarter's report for a full analysis of identified barriers in the civil service hiring process as they relate to the timely hiring of care coordinators in CAMHD. The average length of time all care coordinator positions have been under recruitment last quarter was 198 days.

The percentage of filled Care Coordinator positions over the quarter for each Family Guidance Center is displayed below.

COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC	KAUAI
92%	78%	51%	75%	79%	75%	93%

As seen above every FGC fell below the performance goal. Maui FGC has only half of its care coordinator positions filled, and is also experiencing vacancies in a number of other key positions. Each of the centers that did not meet the goal experienced one to four vacancies during the quarter. The inability to fill positions impacts caseloads.

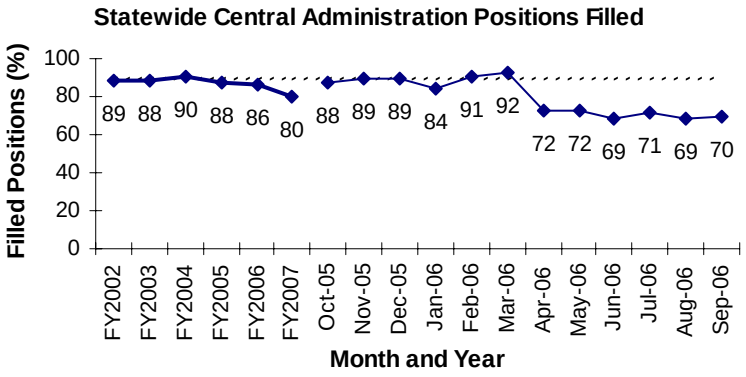
Branch Chiefs receive weekly briefings from the CAMHD personnel office to facilitate communication and understanding when hiring obstacles are encountered.

Goal:

⇨ **90% of central administration positions are filled.***

Like the percentage of care coordinator positions filled measure, this measure was adjusted beginning last quarter to exclude any temporary hires.

The performance target did not meet the desired performance with an average of 70% of central administration positions filled over the quarter.



This is a decrease from last quarter's performance of 71%, and represents the fourth consecutive quarter CAMHD has missed the performance goal. At the end of the quarter, 25 of the 83.25 positions in the Central Administrative Offices were vacant for a 30% vacancy rate. Central Office staff perform provider agency and system monitoring, billing, information system management, contracting, training and other key service system functions.

This is the largest vacancy rate to date for CAMHD's central office infrastructure. Last quarter held the previous record for high vacancies in the CAMHD Central Offices. These positions are about half civil service and half exempt. Additionally, higher-level clinical positions have been difficult to fill because of the existing process required to fill above the established position salary.

Vacant positions are distributed throughout central administration, with all offices experiencing some vacancies, including the MIS system, billing positions (including a position to develop the third-party billing system), and the program monitoring area. In the quarter, CAMHD was able to fill the Practice Development Supervisor position, which had been vacant since February 2006. Consultation and training for the service system, and system leadership for evidence-based interventions is expected to improve as a result.

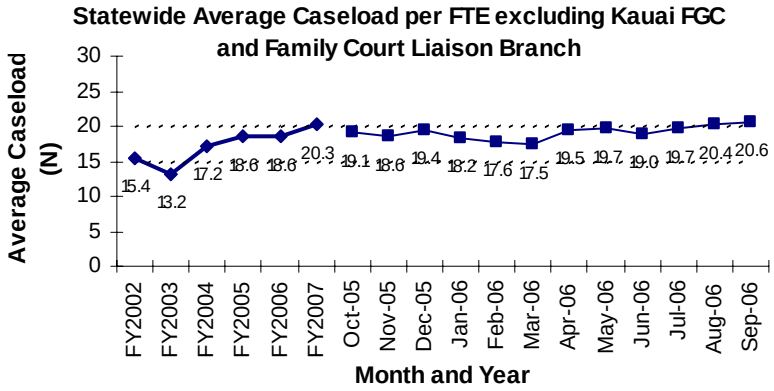
Recruitment and retention of employees is further impacted by the Civil Service Replacement project where all exempt positions are required to be replaced by civil service positions. The civil service requirements will impact current employees in a number of ways from inability to meet length of time in service requirements, to lack of crosswalk to current salaries. These factors add to the difficulty in attracting new employees and retaining current staff in a job market that is already strained in Hawaii. CAMHD has drafted administrative bills for the next Legislative session designed to guide this process. Several positions will be requested to be exempt per a revision to 334-4, and those that convert to Civil Service will have guidelines established.

Goal:

⇨ **Average mental health care coordinator caseloads are in the range of 15 - 20 youth per full time care coordinator.**

It is expected that care coordinator caseloads consistently fall in the range of 15 to 20 youth per full time care coordinator in order to provide quality intensive case management services. The statewide average caseload for the first quarter was beyond the target range at 20.2 youth per full time care coordinator equivalent (FTE), which does not meet the performance goal for the measure.

This is the first time that caseloads have not met the goal of being in the accepted range. Caseloads are at their highest level since performance on this measure began tracking in FY2002. Prior to going beyond the range this quarter, average caseloads had been in the high end of the range statewide for nearly two years.



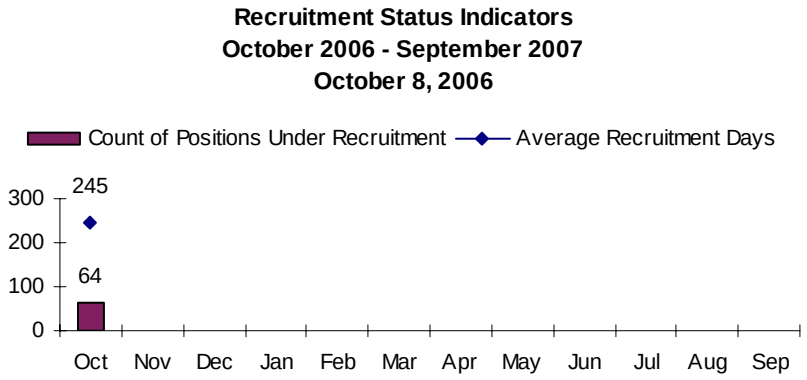
The average caseload performance target was not met for Leeward Oahu and Hawaii FGCs, where caseloads were considerably beyond the expected range. Maui, Windward, and Honolulu are all at or nearing the upper end of the expected caseloads. Central was at the lower end of the range. It should be noted that Leeward and Hawaii are the two communities that are impacted by socio-economic variable and demographics that include high multi-agency involvement and higher functional impairment of youth, making case management often more of a challenge.

Average Caseloads by Family Guidance Center

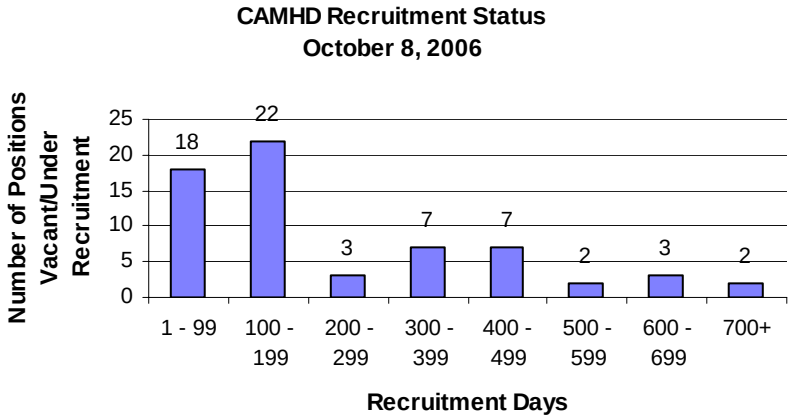
	COFGC	LOFGC	MFGC	WOFGC	HOFGC	HFGC
1st Quarter Average	15	23	19	19	18	27

The calculation of average excludes Kauai, which serves both high-end and low-end youth through the Mokihana project, and therefore have higher caseloads. Family Court Liaison Branch is also excluded because staff provide direct services to youth while at Detention Home or Hawaii Youth Correctional Facility, the majority of which are receiving care coordination from another Family Guidance Center.

Further data regarding the status of recruitment for CAMHD positions are presented below. Of the sixty-four (64) positions currently under recruitment, the average number of days they have been under active recruitment is 245 days, or just over eight months.



The chart below displays the number of positions under recruitment related to the number of days they have been vacant. Recruitment days range from one day to two years. As discussed previously, the process for filling positions under civil service recruitment requirements largely influences the length of time it takes to fill positions. Vacancies are further impacted by low unemployment rates in Hawaii, and the difficulty of recruiting healthcare professionals. While vacancies impact all levels of work in CAMHD, the Family Guidance Centers feel the effect the most as they are the front line that provides care management for youth and families receiving services.



CAMHD will maintain sufficient fiscal allocation to sustain service delivery and system oversight

Goal:

⇨ **Sustain within quarterly budget allocation.**

CAMHD met the goal for sustaining within its budget. The reporting quarter for this performance measure is April 2006-June 2006, which allowed for closing of the contracted agency billing cycle. Expenditures for Branch and Services totals were below budget ($144,000 and $21,000 respectively). The Central Office total was also below budget by $138,000. Total variance from the budget for the reporting quarter was under projection by a total of $450,000. Sufficient funds were encumbered for all expected costs. Given the personnel vacancies at the branches and in the central administrative office, there has been a steady savings of personnel costs. Although this funding saved is not always maintained within CAMHD, CAMHD makes a request each quarter to protect this allocation for reinvestment into the children's mental health system.

Variance from Budget (in $1,000's)

	FY 2002 Average	FY 2003 Average	FY 2004 Average	FY2005 Average	FY2006 Average	2005.1	2005.2	2005.3	2005.4	2006.1	2006.2	2006.3	2006.4
Branch Total	$164	-$150	$20	-$242	-$261	$20	-$337	-$338	-$312	-$159	-$416	-$325	-$144
Services Total	$798	-$4,175	-$1,849	-$102	-$181	-$2	-$203	-$155	-$49	-$105	-$351	-$247	-$21
Central Office Total	-$189	-$388	-$314	$68	-$8	-$15	-$30	$86	$231	$148	$118	-$159	-$138
Grand Total	$773	-$4,713	-$2,142	-$276	-$450	$4	-$571	-$407	-$129	-$116	-$648	-$732	-$303

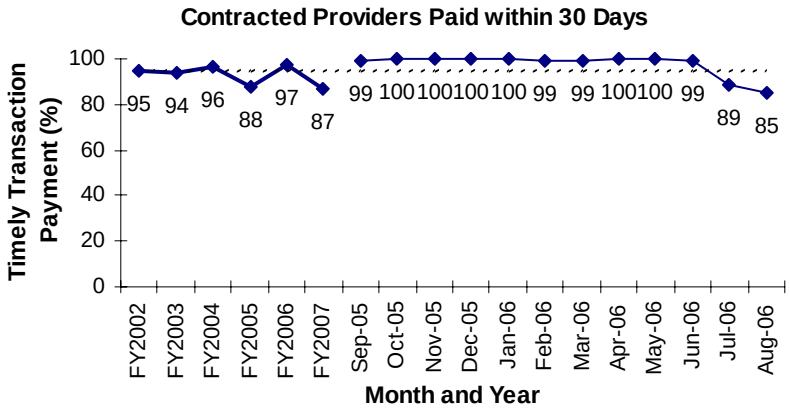
CAMHD will maintain timely payment to provider agencies

Goal:

⇨ **95% of contracted providers are paid within 30 days.**

This quarter, 87% of contractors were paid within the 30-day window over the quarter. As is standard for this report, the quarter's data is available for the first two months of the quarter (July and August 2006) and includes June 2006.

Performance for this measure fell short of meeting its goal. The performance goal had been consistently met since May 2005; the inability to pay providers on time represents a major setback in CAMHD's historically strong fiscal practices.



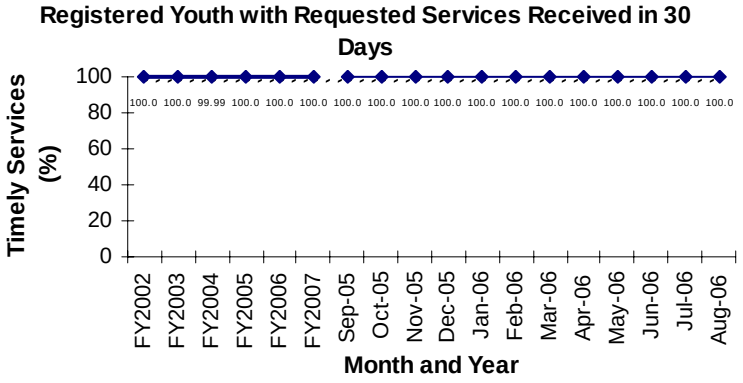
The drop in timely payments is attributed to a number of factors associated with the start-up of contracts pursuant to the new RFP for comprehensive services. In certain instances, delay in submittal of documentation requirements from providers caused a delay in executing contracts. The majority of delays were caused by an extended review process by the State related to the increased scope of work in the contracts. In the future, increased staffing will be added to the professional review process to avoid delays in executing contracts.

CAMHD will provide timely access to a full array of community-based services

Goal:

⇨ **98% of youth receive services within thirty days of request.***

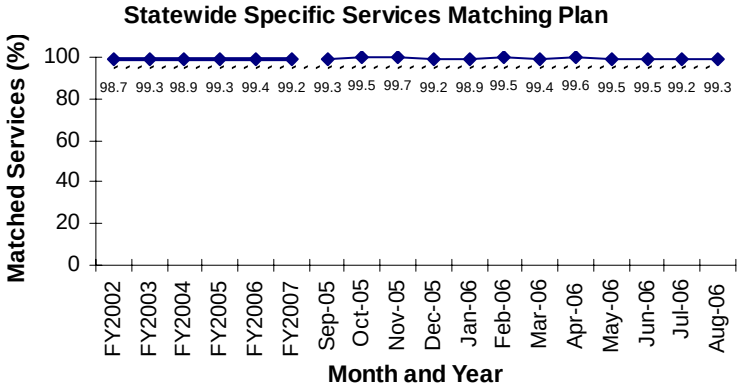
The goal was met for the quarter with 100% of youth provided timely access to services. Data are for the first and second month of the reporting quarter (July and August 2006) as third month data are not available at the time of publication. June 2006 data are included in the average for the quarter. This measure has consistently met the goal since it began to be tracked in fiscal year 2002.



Goal:

⇨ **95% of youth receive the specific services identified by the educational team plan.***

CAMHD continued to demonstrate strong performance on this measure. Over the quarter, 99.3% of youth received the specific services identified by their team plan. Data are for the first and second month of the reporting quarter (July and August 2006) as third month data are not available at the time of publication. June 2006 data are included in the average for the quarter. This measure also includes SEBD youth who do not have an educational plan.



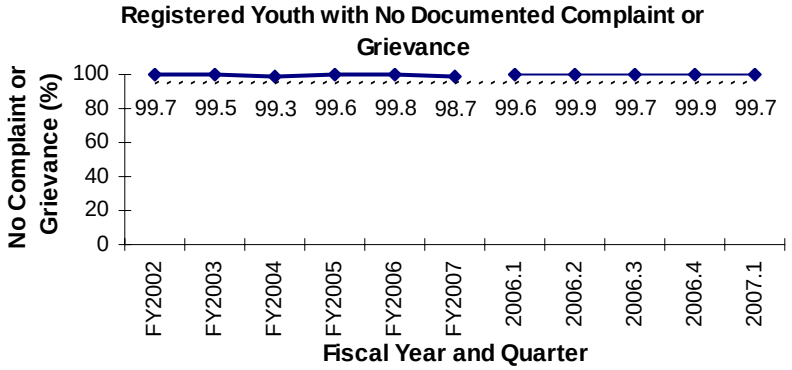
In the quarter, service mismatches occurred in twelve complexes, which is consistent with the previous quarter. Lahainaluna and Waiakea Complexes each had three youth receiving mismatched services. The remaining complexes each experienced one mismatch. Hilo and Pearl City had continuing mismatches from the previous quarter. The regional FGCs and the Utilization Management Committee regularly conduct analyses of the mismatches.

CAMHD will timely and effectively respond to stakeholders' concerns

Goal:

⇨ **95% of youth served have no documented complaint received.***

99.7% of youth served in the quarter had no documented complaint received, which exceeds the performance goal. The target was met across all Family Guidance Centers. Performance on this goal has been sustained since it was established in June 2001.

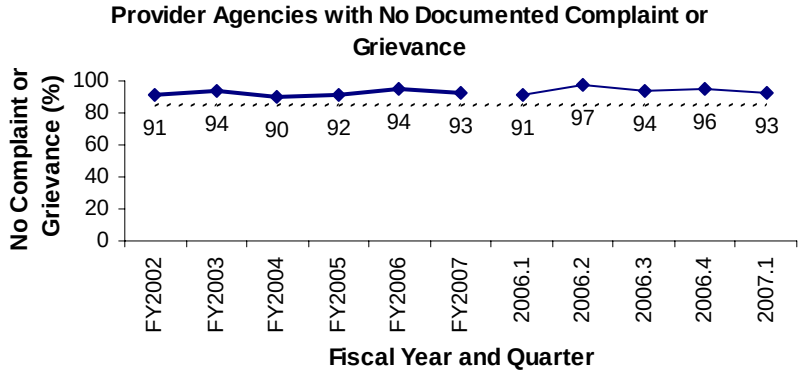


In the quarter, there were complaints received from 5 youth (or someone complaining on their behalf) representing 5 complexes statewide as compared to 1 youth with a documented complaint representing 1 complex last quarter. There was one complaint for each of the following complexes: Kalaheo, Na'alehu, Waiakea, Kapolei, and Nanakuli. Kapolei and Nanakuli had one complaint each, although case management services were being provided by the Hawaii Family Guidance Center. None of these complexes had complaints the previous reporting quarter.

Goal:

⇨ **85% of provider agencies have no documented complaint received.**

93% of provider agencies had no documented complaint registered about their services, which was below last quarter's performance, but met the targeted goal. The performance target for this measure has been consistently met since the second quarter of fiscal year 2004. It is recommended that the benchmark for this measure be adjusted upward to reflect the trend.

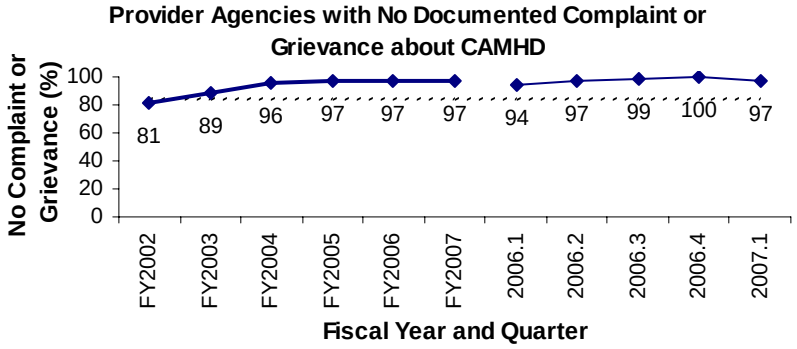


Goal:

⇨ **85% of provider agencies will have no documented complaint about CAMHD performance.***

In the quarter, 97% of agencies in the CAMHD provider network had no documented complaint or grievance about CAMHD, which was slightly less than last quarter's performance when no complaints were received. This measure has consistently met the performance goal since the beginning of FY 2003. Again, it appears that an adjustment to the performance goal is in order.

Although not received as formal complaints, a number of agencies have raised the issue of financial loss due to fewer referrals.



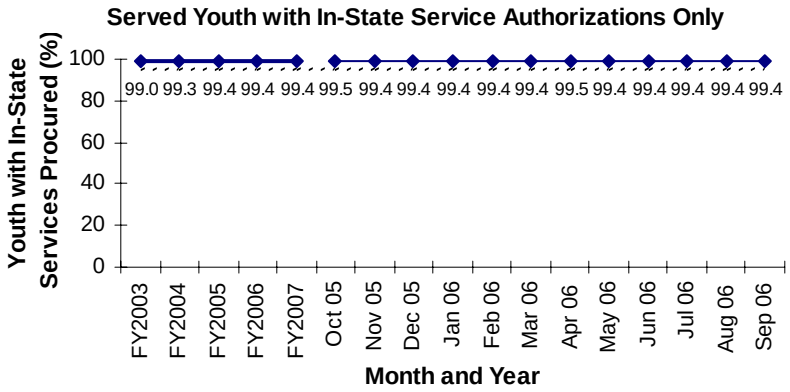
Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting

Goal:

⇨ **95% of youth receive treatment within the State of Hawaii.***

In the quarter, an average of 99.4% of CAMHD registered youth served received treatment within the State, which exceeds the goal. Six youth received services in out-of state treatment settings in each month of the quarter.

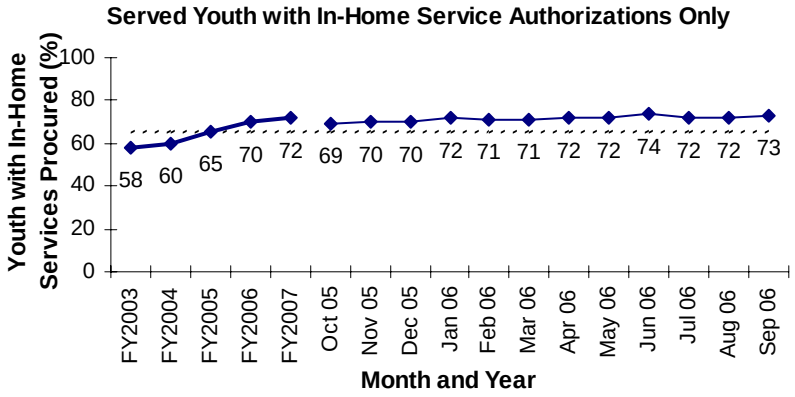
These data represent only youth registered with CAMHD who were in out-of-state treatment settings in the reporting quarter, and does not represent youth who may have this service paid for by another State agency.



Goal:

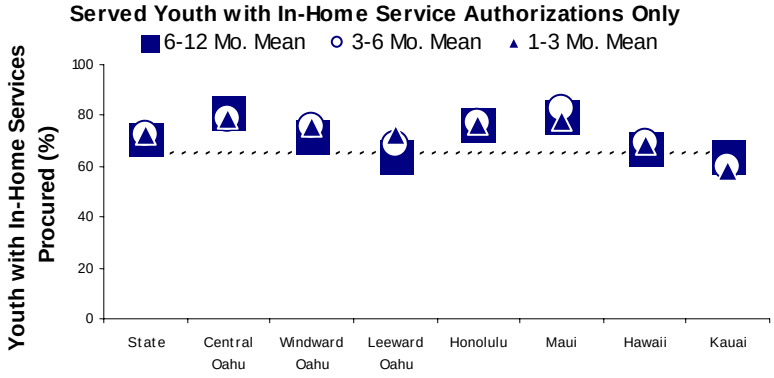
⇨ **65% of youth are able to receive treatment while living in their home.**

An average of 72% of youth were served in their home communities during the quarter, which is 7% above the performance goal. This quarter's performance was slightly below last quarter's average of 73% of youth served in their homes. The in-home services performance measure is calculated at the percent of youth who did not receive an out-of-home service authorization during the quarter and either received an in-home service authorization or were enrolled in the CAMHD Support for Emotional and Behavioral Development (SEBD) program divided by the total number of youth with a service authorization or SEBD enrollment during the period.



The pattern of improved performance on this measure reflects both the expansion of the SEBD program and increased use of home and community services coinciding with marked decreases over the last year in utilization of residential services. A recommendation regarding a new performance goal for this measure is under study.

There was variable performance across the Family Guidance Centers in meeting the goal as can be seen below, however performance appeared consistent within their own historical patterns.



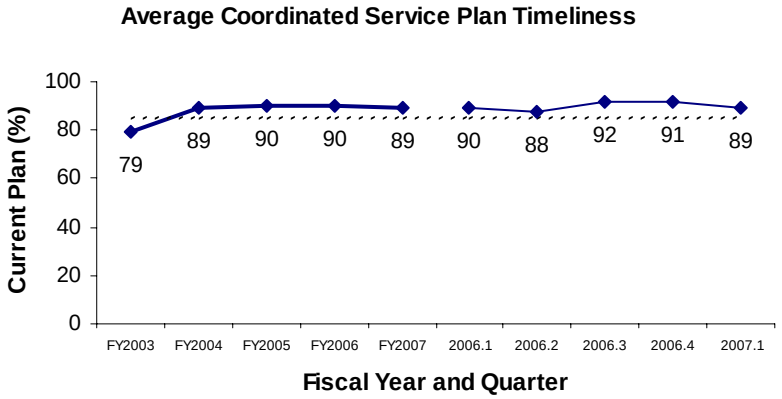
The goal was met for all Family Guidance Centers with the exception of Kauai. Kauai, through the Mokihana Project, operates under a markedly different service delivery model than the rest of the State. The integrated school-based model has resulted in a smaller percentage of the overall population of youth on Kauai receiving high-end services.

CAMHD will consistently implement an individualized, child and family centered planning process

Goal:

⇨ **85% of youth have a current Coordinated Service Plan (CSP).***

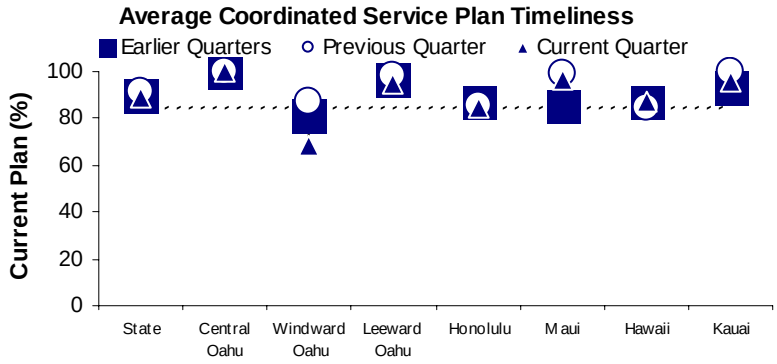
CAMHD's performance in this measure met the performance goal for the reporting quarter with 89% of youth across the state having a current CSP as compared to 91% last quarter. The performance has remained fairly stable statewide and the goal has been met for the past three years.



Note: This data includes youth who were newly admitted to CAMHD who have not yet had a CSP developed, but does not include youth awaiting an assessment for determination of SEBD.

"Current" is defined as having been established or reviewed with the CSP team within the past six months. Quarterly reviews for timeliness are conducted by each FGC. Registered youth are to receive an initial Coordinated Service Plan within 30 days of determination of eligibility.

Trend data for each FGC are displayed below. The goal was met in all of the FGCs with the exception of the Windward FGC, which saw a substantial; decline in the timeliness of their plans. They will be asked to implement an improvement plan to address this performance issue. There were no significant concerns in other parts of the state.

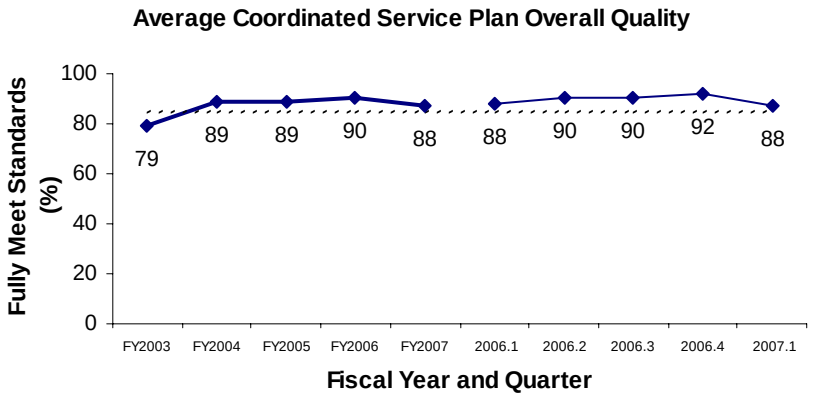


In the previous quarter, Maui FGC experienced a decline in performance. This quarter, the FGC rebounded significantly, and almost met the 100% mark.

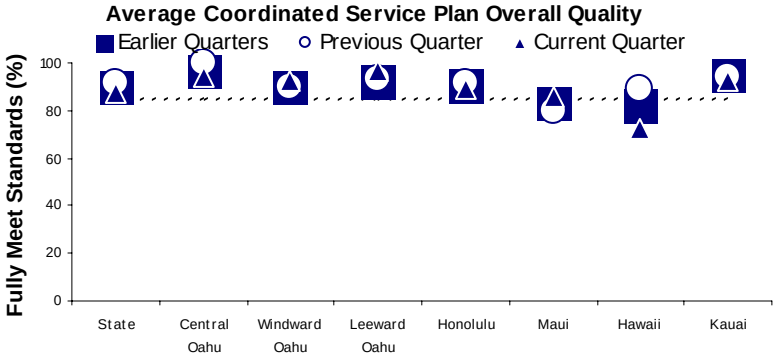
Goal:

⇨ **85% of Coordinated Service Plan review indicators meet quality standards.***

The goal for this measure was met statewide in the reporting quarter with 88% of CSPs sampled meeting overall standards for quality, which was a decline from last quarter's results of 92% of plans meeting quality standards. The goal has been met for the past three years at the statewide level.



CSPs are reviewed quarterly by the FGCs to determine if they meet the standards for effective plans. In order for a CSP to be deemed as acceptable overall, there must be evidence that the plan is meeting key quality indicators including stakeholder involvement, clear understanding of what the child needs, individualization of strategies, identification of informal supports, long-term view, plan accountability, use of evidence-based interventions, crisis plans and several other key measures.



As seen in the chart above, the goal was met or exceeded by all FGCs with the exception of Hawaii Family Guidance Center (HFGC), which experienced a significant decline in performance. Last quarter, 89% of HFGC's plans, were found to meet standards of performance as opposed to only 72% in the reporting quarter. HFGC has struggled with the

quality of their plans over the past year, and performance may be attributable to high Care Coordinator vacancy rate. HFGC has filled a number of their positions with temporary employees, which does appear to give them the necessary stability to assure quality plans on an ongoing basis.

Maui FGC, which experienced a dip in performance last quarter rebounded this quarter, and met the performance goal.

There will be a statewide community-based infrastructure to ensure quality service delivery in all communities

Goal:

⇨ **85% of performance indicators are met for each Family Guidance Center.**

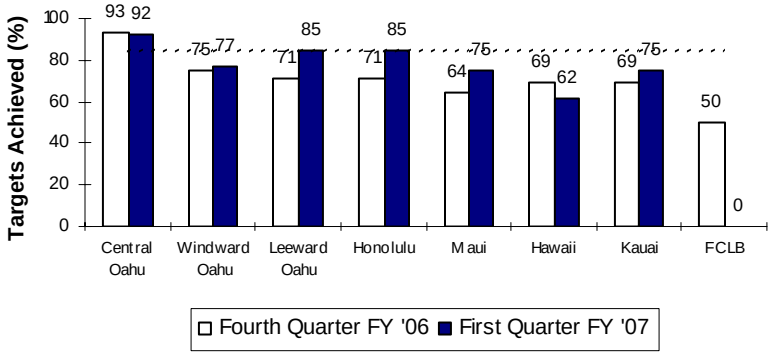
Three of the eight Family Guidance Centers: Central, Leeward, and Honolulu FGCs, met their performance goals this quarter. Last quarter only one FGC met the goal.

Family Guidance Center performance is evaluated based on the percentage of performance targets that are met or exceeded in the quarter. Performance targets are comprised of the relevant measures presented in this report, and include individual FGC performance on: personnel measures, expenditures within budget, grievances, access to services (service gaps/mismatches), least restrictive environment (served in-home), timeliness and quality of coordinated service plans, performance on internal reviews, improvements in child status, and family satisfaction. Improvements were seen in the quarter in many of these indicators. The indicator for "maintaining within budget" was not applicable this quarter as funds were used from savings in certain FGCs to meet shortages in other areas to manage the needs of the system.

Across all branches, 68.9% of all goals were met in the quarter, compared to 70.3% in the last quarter, and 75.8% over the same period last year.

Leeward and Kauai showed improvement over the previous quarter and over the same period of last year. Windward, Maui, Hawaii, and Kauai FGCs and the Family Court Liaison Branch (FCLB) did not meet performance goals. Leeward, Hawaii, and Kauai showed improvement over the same period last year. Windward, Honolulu, Maui, and FCLB showed declines, whereas Central remained stable.

FGC Performance Indicators Successfully Achieved



Due to its unique configuration, the FCLB is generally only evaluated for the two indicators: expenditures within budget and percent of youth showing improvement on the CAFAS or ASEBA. Therefore these results tend to be highly variable and are not directly comparable to other branches.

The branches did well on indicators of:

- timely access to services,
- providing services identified by the educational team plan,
- documented complaints from consumers, and
- serving youth in the State.

One or two branches did not meet goals for:

- average caseloads,
- serving youth while they are living at home,
- timeliness of Coordinated Service Plans,
- quality of Coordinated Service Plans,
- maintaining acceptable scoring on Internal Reviews, and
- youth with acceptable child well-being in Internal Reviews.

Several branches did not meet the goal for:

- youth showing improvements as measured by the CAFAS or ASEBA, and
- completing the CAFAS or ASEBA.

None of the branches met the performance goal for:

- filling care coordinator positions.

The following indicators were not applicable for the reporting quarter:

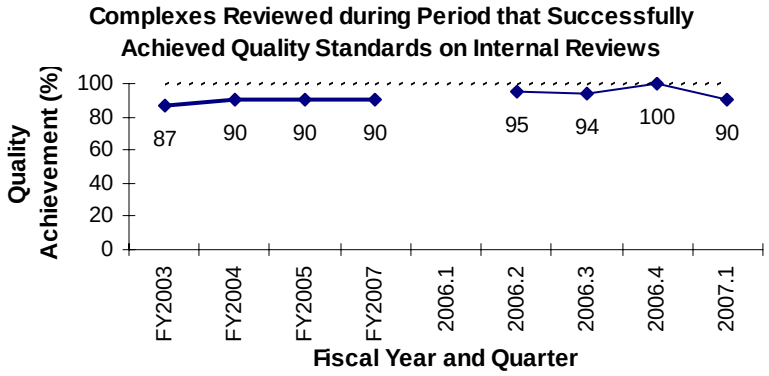
- maintaining within budget,
- family satisfaction, and
- service system satisfaction.

Performance goals not met by a Family Guidance Center are addressed through specific improvement strategies developed by the FGC internal quality assurance committee, and reported up through the CAMHD Performance Improvement Steering Committee. Each FGC management team tracks the implementation of their improvement strategies.

Goal:

⇨ **100% of complexes will maintain acceptable scoring on internal reviews.***

Complex internal and external reviews for the school year started in the first quarter. Of the ten complexes reviewed, all met the system performance goal, but one fell short of the goal for child status. One complex, Pahoa fell short of the goal at 83% for acceptable child status. This result falls short of the performance goal for the quarter with 90% of complexes achieving the goal for acceptable performance. Acceptable scoring continues to be defined as achieving acceptable system performance and child status for 85% of cases reviewed. The performance target is for 100% of complexes to meet the goal for acceptable system performance and child status.

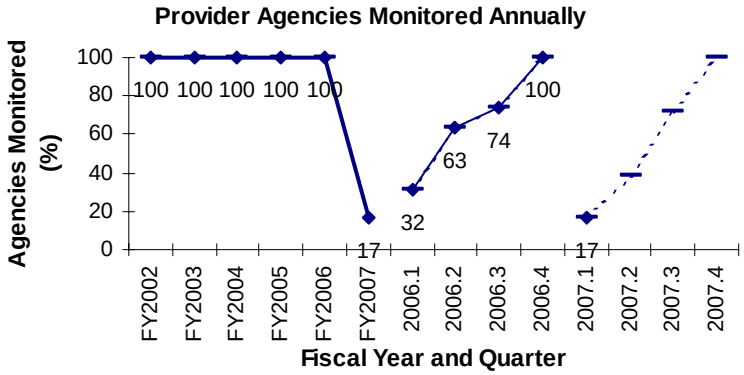


Mental Health Services will be provided by an array of quality provider agencies

Goal:

⇨ **100% of provider agencies are monitored annually.**

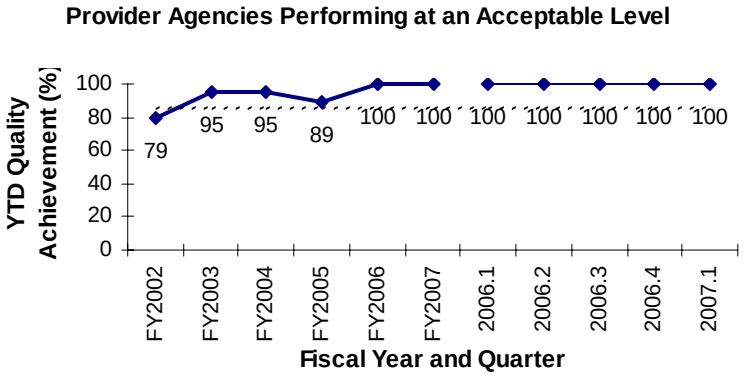
The CAMHD Performance Management Section conducts comprehensive monitoring of all agencies contracted to provide mental health services. In the quarter, 17% of all agencies contracted to provide direct mental health services were monitored as scheduled, which met the targeted goal. Three agencies, representing three contracts and four levels of care were monitored in the first quarter. The monitoring tools for reviewing provider agencies have been redesigned, adding to the specificity of feedback regarding quality of practice and. alignment with standards.



Goal:

⇨ **85% of provider agencies are rated as performing at an acceptable level.**

At least annually, provider agencies are reviewed across multiple dimensions of quality and effective practices. In the reporting quarter, 100% of the provider agencies reviewed in the quarter were determined to be performing at an acceptable level, which met the performance goal for this measure. Because monitoring occurs over an annual season, the annual indicator is more reliable than the quarterly indicator. For example, one agency experienced a number of performance issues in the quarter, but because the annual review is not scheduled until later in the year, the measurement does not reflect that agency's performance in this quarter's report.

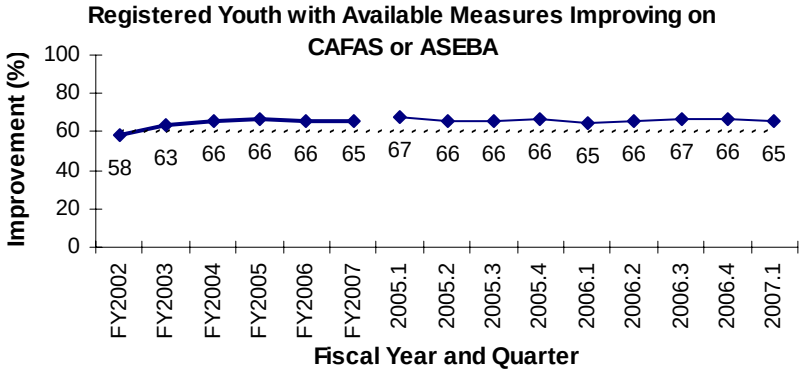


CAMHD will demonstrate improvements in child status

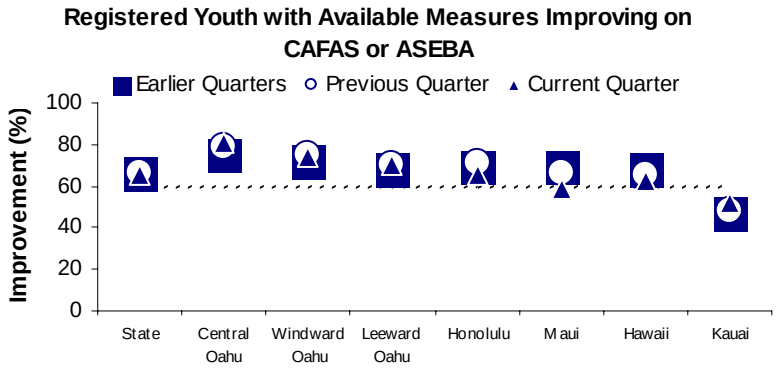
Goal:

⇨ **60% of youth sampled show improvement in functioning since entering CAMHD as measured by the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment (ASEBA).***

To monitor performance of CAMHD's goal of improving the functioning, competence and behavioral health of youth, care coordinators are required to submit the CAFAS and ASEBA for each youth. The performance goal is measured as the percentage of youth sampled who show improvements since entering CAMHD services and is set at 60%.



In the reporting quarter, for youth with data for these measures, 65% were showing improvements since entering the CAMHD system, which exceeds the performance goal. This indicator had demonstrated improvements from fiscal year 2002 to 2004, but has settled on a plateau of approximately two-thirds of youth showing improvement at any given point in time. The benchmark for this measure is under review by the Branch Chiefs, who will make a recommendation regarding elevating the goal to the CAMHD Executive Management Team.

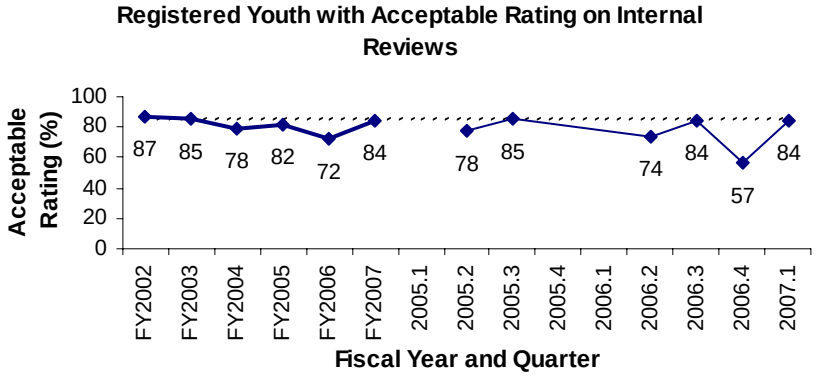


Most branches are performing near the state average with the exception of Kauai, which historically has performed below the average. Kauai's population differs from the other branches due to the Mokihana project, so the branch-to-branch results are not directly comparable. While all are performing above the state average, Windward and the Big Island experienced a slight dip in performance and Honolulu and Maui experienced more of a moderate dip in performance this quarter. Maui did not meet the goal.

Goal:

⇨ **85% of those with case-based reviews show acceptable child status.**

Of youth receiving care coordination and services through CAMHD, 84% statewide were found to be doing acceptably well on measures of child well-being as measured through Internal Reviews, which was slightly below the goal. Child status was a concern for several youth reviewed in the Hawaii service area. Systematic review of all youth who have unacceptable child status and system performance is now conducted by the Family Guidance Centers through a review protocol.



Families will be engaged as partners in the planning process

Goal:

⇨ **85% of families surveyed report satisfaction with CAMHD services.**

CAMHD performs an annual consumer survey in the spring of each year and results were reported last quarter. Therefore, new data are not available for the current report.

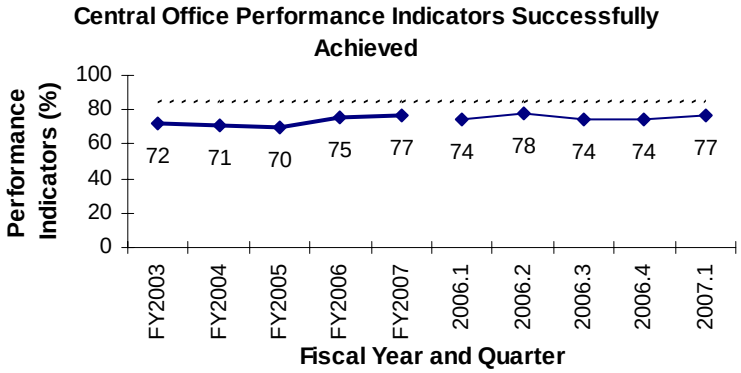
The comprehensive report of the most recent results can be found on the CAMHD website at http://www.hawaii.gov/health/mental-health/camhd/library/pdf/rpteval/cs/cs007.pdf

There will be state-level quality performance that ensures effective infrastructure to support the system

Goal:

⇨ **85% of CAMHD Central Office performance measures will be met.**

CAMHD's Central Administrative Offices utilize performance measures for each section for accountability and planning. Central Office measures are approved and tracked by the CAMHD Expanded Executive Management Team (EEMT). There are a total of 36 measures currently tracked by EEMT. Of the 30 measures available in this quarter, 23 or 77% of measures were successfully met, which falls short of meeting the performance goal for this quality indicator, but shows a slight increase over last quarter's performance of 74%. In the quarter, the measures that fell below their goals centered around vacancies, timely resolution of grievances, timely completion of provider monitoring reports, and timeliness of requesting corrective actions plans for facility certification

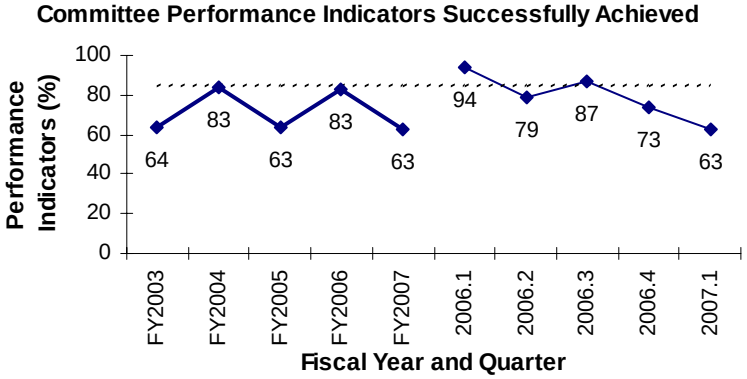


Improvements for Central Office performance measures are managed by respective sections of CAMHD. When solutions require a broader organizational intervention, these are discussed at the Expanded Executive Management Team level, and are tracked for implementation.

Goal:

⇨ **85% of CAMHD State Committees performance measures will be met.**

The CAMHD Performance Improvement Steering Committee (PISC) reviews data for its core committees, which include Grievance Appeals, Compliance, Credentialing, Evidence Based Services, Information System Design, Policy & Procedure, Safety & Risk Management, Training, and Utilization Management.



A total of 22 measures are tracked and reported on in the monthly meeting. Similar to Central Office measures, results for each indicator are discussed in PISC meetings in order to identify improvement strategies that are implemented by respective CAMHD section managers.

In the quarter, of the 16 measures with available data, 63% were successfully achieved through the work of the CAMHD Committees. This is a decrease over last quarter's performance of 73% of measures met. There were six committee measures not meeting the benchmark Safety and Risk Management, Credentialing (4), and Utilization Management. Each committee not meeting their benchmark is required to present improvement strategies to PISC.

Summary

Slightly more than half of performance goals were met or exceeded in the first quarter of fiscal year 2007 (July 2006-August 2006), which is consistent with last quarter's overall performance.

For a point of reference, the asterisked measures are those that had historically been linked to Federal Court benchmarks under the Felix Consent Decree. Of these "Sustainability" measures, indicators met the performance goal in the reporting quarter except for the following measures:

- Filled Care Coordinator Positions, which was 18% below targeted performance, and a decline of 8% from last quarter's performance.
- Filled Central Administration Positions, which was below (20%) the targeted performance goal and 1% lower than last quarter's performance.

The following were measures that met or exceeded goals:

- Maintaining services and infrastructure within the quarterly budget allocation
- Timely access to the service array:
  - Youth receiving services within 30 days of request*
  - Youth receiving the specific services identified on their plan*
- Timely and effective response to stakeholder concerns:
  - Youth with no documented complaint received*
  - Provider agencies with no documented complaint received
  - Provider agencies with no documented complaint about CAMHD performance*
- CAMHD-enrolled youth receiving treatment within the State of Hawaii*
- CAMHD-enrolled youth receiving treatment while living in their home
- Coordinated Service Plan timeliness*
- Coordinated Service Plan quality*
- Performance Indicators met by the Central Family Guidance Center
- Performance Indicators met by the Leeward Family Guidance Center
- Performance Indicators met by the Honolulu Family Guidance Center
- Monitoring of provider agencies
- Quality service provision by provider agencies
- Improvements in child status as demonstrated by CAFAS or ASEBA*

The following measures were below targeted performance with observed decreases, and will require implementation of improvement strategies developed by the appropriate monitoring bodies.

- Filled Care Coordinator positions*
- Filled Central Administration positions*
- Care Coordinator caseloads within the range of 1:15-20 youth
- Contracted providers paid within 30 days
- Performance Indicators met by the Windward Family Guidance Center
- Performance Indicators met by the Maui Family Guidance Center
- Performance Indicators met by the Hawaii Family Guidance Center
- Performance Indicators met by the Kauai Family Guidance Center
- Performance Indicators met by the Family Court Liaison Branch
- Complexes maintaining acceptable scoring on Internal Reviews*

- Child Status as measured by Internal Review Results
- State Committee performance indicators
- Central Office performance indicators

The following measures were not completed this quarter due to regular annual scheduling:

- Overall satisfaction with counseling or treatment
- Overall satisfaction with company handling benefits

Of the 31 performance measures completed during this quarter, only 16 or 55% of performance indicators met or exceeded goals. Two measures that did not meet the performance goal last quarter met the goal in the current quarter. Almost half of the measures experienced performance declines. Of the original "Sustainability" measures, three (Filled Care Coordinator positions, Filled Central Administration positions, and Complexes maintaining acceptable scoring on Internal Reviews) did not meet the performance goal. This corresponds with the previous reporting quarter, with the exception of one of the measures (Complexes Maintaining Acceptable Scoring on Internal Reviews). Challenges to filling positions remain a core issue impacting performance across functions. Vacancies in the MIS, Administrative Offices, Clinical Services, and Performance Management sections continue to challenge ongoing operations. Additionally, performance areas of concern in the Family Guidance Centers continue to be impacted by vacancies and the time it takes to fill positions. These issues have been cited over the past year and a half.

Recommendations for improvement cited in this report are tracked through the CAMHD Performance Improvement Steering Committee.

The performance measures that have an impact on several other areas of measurement is that of "positions filled." These measures are directly linked to central office measures of each section's performance, the CAMHD Committee measures, and the Branch Care Coordinator positions. When FGC's care coordinator positions are not filled, and each individual's workload or caseload goes up, there is less time for each care coordinator to work with each family and youth. The effect of this lack of availability is an over reliance on residential placement. Institutional care is often easier to manage for the community based care coordinator as it requires less day-to-day attention from staff. This pattern is evident in the increase in the use of hospital level care and community based residential treatment. Given that the highest population CAMHD serves is youth with disruptive behaviors, the evidence based research literature tells us that this is the exact opposite practice that we want to support. It is not effective with this population and at times, it has been found to be harmful. In addition, hospital level care and community based residential treatment are the most expensive services in the CAMHD array. The conclusion that can be drawn is that due to inability to recruit and hire personnel in a timely way, as evidenced by the data presented, the CAMHD system is relying on more restrictive, less effective and more costly services than the literature would tell us were beneficial.

CAMHD recommends that state leadership intervention is warranted to address this issue.